

**Summary of the Meeting of the Task Force on the Development of a Plan to Guide the
Future Mental Health Service Continuum**

**Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215**

February 26, 2008

Task Force Members Present:

Rex M. Cowdry, M.D., Chair	Maryland Health Care Commission
Harry A. Brandt, M.D.	Maryland Psychiatric Society, Inc.
Tracee E. Bryant	Black Mental Health Alliance
Laura Cain	Maryland Disability Law Center
Herbert S. Cromwell	Community Behavioral Health Association
Thomas J. Crowley	Doctors Community Hospital
Suzanne Harrison	Sinai Hospital of Baltimore – LifeBridge Health
David T. Jones, M.S.	Montgomery Co. Dept. of Health & Human Services
Bonnie Katz	Sheppard Pratt Health System
Pamela King	On Our Own of Montgomery County
James Macgill, Jr.	Management and Planning for Health and Human Service Organizations
Sako Maki, M.S.W., M.P.H.	Potomac Ridge Behavioral Health Services
Robert Murray	Health Services Cost Review Commission
Linda J. Raines	Mental Health Association of Maryland
Gayle Jordan-Randolph, M.D.	Mental Hygiene Administration
Mark A. Riddle, M.D.	The Johns Hopkins Hospital
Arleen Rogan, Ph.D., LCSW-C	Department of Juvenile Services
Robert Rothstein, M.D.	American College of Emergency Physicians
Sally Tyler	AFSCME
Donna Wells, LCSW-C	Maryland Assn. of Core Service Agencies
Brenda Wilson	Maryland Insurance Administration

Commission Staff Present:

Pamela W. Barclay
Paul E. Parker
Eileen Fleck

Mental Hygiene Administration Staff Present:

Daryl Plevy
Stacy Rudin

Others Present:

Elizabeth Barnard	DHMH Office of Capital Planning
Peter Cohen, M.D.	Alcohol and Drug Abuse Administration
Colette Croze	Croze and Associates

Lisa Cuzzo	Mental Health Association of Maryland
Esther Diggs	Department of Juvenile Services
Gerri Gray	National Alliance on Mental Illness
Howard H. Goldman, M.D., Ph.D.	University of Maryland, Baltimore
Lynne Humphries-Russ	Maryland Coalition of Families
Steve Ports	Health Services Cost Review Commission
Timothy Santoni, M.A.	University of Maryland, Baltimore
Sandra Sundeen, M.S., R.N.	University of Maryland, Baltimore
Pegeen Townsend	Maryland Hospital Association

1. **Call to Order**

Dr. Rex Cowdry, Task Force Chair, called the meeting to order at 10:00 a.m., welcoming members of the Task Force and others in attendance. Members of the Task Force introduced themselves and stated their affiliations. Dr. Cowdry noted that the Task Force has a great deal of work to do with limited time. Therefore only Task Force members will be seated at the table and recognized to speak during meetings. If members are unable to attend a meeting they may send a representative who will sit in the audience and listen to the proceedings.

2. **Review of Task Force Charge from the Joint Chairmen's Report**

Ms. Barclay reviewed the origination of the Task Force. It was an assignment to the Commission that was in the 2007 Joint Chairmen's Report. This assignment resulted from work that the Commission carried out in response to the 2006 Joint Chairmen's Report, which asked the Commission to study the issue of Emergency Department overcrowding. Two of the recommendations of that study addressed psychiatric services and said that the Department of Health and Mental Hygiene should develop a plan related to the capacity of the State Mental Health System and that the Commission should investigate the capacity of acute general hospital psychiatric services. These two approaches were combined and resulted in the formation of this Task Force.

The Task Force is charged with developing a plan that shall include a statewide mental health needs assessment of the demand for inpatient hospital psychiatric services in acute general hospitals, private psychiatric hospitals and State hospitals. In addition, the Task Force should consider the community-based services and programs needed to prevent or divert patients from admission to inpatient mental health services including services provided in hospital emergency departments.

The Commission has several partners in this enterprise, including the Transformation Project of the Mental Hygiene Administration, as well as other members of the Mental Hygiene Administration executive staff. The Transformation Project has provided funding for consultants who will prepare White Papers and a statistical profile to assist the Task Force in accomplishing its charge. These include staff from the Systems Evaluation Center at the University of

Maryland, Baltimore and Ms. Colette Croze, an independent consultant who will work with the University.

3. Review and Discussion of Task Force Work Plan and Timetable

Ms. Barclay reviewed the timetable for the project. The Commission received from the Joint Chairmen an extension of the deadline for completion of the plan until December 1, 2008. In order to meet this deadline, the Commission projected having a small number of Task Force meetings that would be long enough to enable productive discussions. The first meeting is scheduled for two hours but it is projected that future meetings would last for ½ day. Refreshments will be provided. The Task Force should complete its activities related to the Plan draft by September, 2008, to leave enough time for public comment and another Task Force meeting to review comments and recommend revisions.

The Work Plan was sent to Task Force members prior to this meeting. A series of White Papers related to various aspects of the plan will be developed and Task Force meetings will be organized around the review of these documents. The meetings will be focused on discussing information, options and issues that are presented in a White Paper. This meeting will focus on the first White Paper which is a framework document which identifies some of the issues that will frame some of the parameters for the plan. White Papers are designed to provoke discussion, which should lead to identification of additional issues.

The second White Paper will present information on the roles of state, private, and acute general hospitals, including utilization and other data on how these settings function in the system. The third White Paper will present information on Best Practices for preventing or diverting patients from emergency department or hospital admissions. The fourth White Paper will consider gaps in the data, as well as tools for improving the quality of mental health services through the use of performance measures and patient experience data. A Statistical Profile of Mental Health Services is also being developed. It will include information about system capacity, utilization and financing. There will also be an effort to benchmark the Maryland data with other states. The final document will be the Plan, which will be developed in stages and presented to the Task Force as it is drafted. It will include some forecasting and some policy recommendations.

4. Review and Discussion of White Paper: Meeting the Needs for Inpatient Mental Health Services: A Framework for Planning

1. What principles should guide this planning effort?

Dr. Cowdry presented thoughts about maximizing the productivity of the White Paper discussions. The documents lay out a perspective, in this case an approach to planning. The Task Force should then have a conceptual discussion about the principles involved, the larger issues, and the tone of the document. Editorial comments can be e-mailed to staff, as can comments that members think of after the meeting. The scope of this effort is limited to the need for inpatient beds and the types of inpatient beds that are needed, as well as how this need can be influenced by different or better or more effective community programs. It does not include

broad consideration of the mental health system. Task Force members expressed no objection to that focus. Dr. Cowdry then provided an overview of the planning principles as identified in the White Paper that would be the focus of the discussion in this meeting.

Dr. Riddle commented on the limited database for children and adolescents related to evidence-based practices, resulting in the need to consider other services as well. Ms. Raines recommended adding a principle related to recovery and outcomes, identifying the need for programs to promote independence thus reducing the need for inpatient and outpatient services. Dr. Riddle added that the unit of service for children and adolescents is really the family. He pointed out that the payer system focuses on individuals, not families. Dr. Cowdry clarified that, in addition to the financing aspect, the need for inpatient services would be related to the effectiveness of family interventions. Dr. Riddle guessed that 1/4 to 1/3 of the child and adolescent admissions could be avoided if they had an adequate place to live, including a family that was functioning well enough to assist them with their difficulties.

Dr. Cowdry noted that, in preparation for the third White Paper, the Task Force should recommend evidence-based practices that may be a challenge in certain areas like family interventions aimed toward reducing inpatient admissions. Mr. Jones supported the idea of identifying evidence-based family interventions, including single adults also. Mr. Cromwell recommended looking at “what is”. He cited environmental factors and co-occurring substance abuse problems as influences on emergency department use. He suggested looking at data describing emergency department users and those who are admitted to inpatient services. He also advised looking at the evidence-based diversion pilot projects that are taking place in some emergency departments. Dr. Riddle identified the need for better health information systems with information from community service provision and previous inpatient admissions available to providers who are dealing with crisis situations. Dr. Rothstein stated that data must address the number of patients who use emergency departments, not just the number of visits. Dr. Jordan-Randolph recommended exploring the types of evaluations completed in emergency rooms as well as the types and experience of evaluators in terms of any relationship to percentage of those admitted as opposed to those diverted. Ms. Maki stated that the issue of emergency department decision-making cannot be addressed without considering the role of physicians and their liability concerns.

Dr. Riddle noted that Maryland’s all-payer system is unique. He questioned the usefulness of DRG’s for predicting resource utilization and cited disincentives for accepting admissions of hard-to-treat patients. Dr. Cowdry agreed that diagnosis is a poor predictor of resource utilization. Dr. Riddle added that the problems with the Maryland system could probably be fixed and the system is, in general, an advantage.

Ms. Raines raised the issues of prevention and early intervention. This group must examine resources currently being invested in these areas and whether there are results that affect usage of the system. The Task Force has to decide whether or not to address this issue and to decide what issues will remain for consideration by another forum at another time. Ms. Harrison stated a concern about the importance of focusing on preventive services to avert crises and related issues of funding. Ms. Maki added that the complexity of funding for services to children and adolescents sometimes becomes a barrier to access. Ms. Harrison raised the issue of

problems with communication and coordination of care related to lack of effective case management. Dr. Riddle emphasized the necessity of examining the whole continuum of care, not just inpatient. For instance financial disincentives for partial hospitalization could drive up inpatient admissions. Ms. King added that consumer-run services are not being fully utilized, frequently due to lack of knowledge that they are available. Dr. Cowdry stated that there is a challenge in finding studies that document the effectiveness of various diversion services in avoiding emergency department and inpatient admissions.

Dr. Cowdry noted that there will not be the ability to gather new data for this report. Characterization of emergency department patients and dispositions is not available at this time. We do know that rates of admission from emergency departments in Maryland are high. Shortcomings in available data will be the subject of an upcoming White Paper. Ms. Cain stated that the Maryland Disability Law Center is in the midst of a two-year project in collaboration with Maryland Hospital Association that is exploring the reasons for people going to emergency departments. So far they are finding that people were unaware of crisis intervention alternatives and that many people were not experiencing crises but were seeking services that they could have received elsewhere. She will share the report with the Task Force.

Dr. Cowdry urged Task Force members to provide information about any evidence-based practices that should be addressed in the third White Paper. Dr. Riddle informed the group about the Children's Services Blueprint Committee that has compiled a list of evidence-based practices for children and adolescents, including a rating methodology and scoring system. Dr. Laurel Kiser at the University of Maryland led this effort. Mr. Jones suggested including wraparound care as one effective approach to services for children and adolescents. Ms. Maki added respite care as another approach.

Ms. Tyler recommended including dual diagnoses of mental illness and substance and also mental illness and developmental disabilities in the analysis of utilization and emergency room admissions. Ms. Maki added that both developmentally disabled children and adults should be included. It can be very difficult to find services for the adults. Ms. Katz announced that Sheppard Pratt will be opening an inpatient unit for developmentally disabled adults with mental illnesses. Mr. Cromwell added that the inpatient population of individuals with both mental illness and developmental disabilities in the State hospitals has been growing and currently stands at 70. Mr. Macgill requested that the dual diagnosis of mental illness and dementia also be included. Ms. Cain raised the issue of the forensic inpatient population and difficulty discharging them because of inadequate community resources that a court would accept. Dr. Jordan-Randolph added that supervision is part of the problem but housing access is very complicated for the forensic population. A similar housing problem exists for children and adolescents who are in residential treatment centers. She also raised non-compliance with taking prescribed medication by as many as 54% of the population as another issue that influences emergency department utilization.

Ms. Harrison suggested that it was important to consider who would not be part of the target population. She noted that mental health often becomes the default service provider because other systems are failing. For instance many people who come to emergency rooms for mental health services really have substance abuse problems. Dr. Riddle responded to this by

saying that the Task Force has to decide whether to focus on Mental Hygiene Administration dollars as opposed to a focus on leveraging this with other major players and other departments. Dr. Cowdry stated that it would be necessary to consider all of the interacting forces, not just MHA. He also cautioned that the Task Force will not be able to resolve the related funding issues. The Task Force must focus on the need for hospital bed services and what programs or services might affect that need without necessarily answering the questions of how they get established or who is responsible for establishing them.

Dr. Cowdry introduced the question of priorities for recommendations and commented that, to some extent, the priorities have to be based on the likelihood of producing the best result for the expenditure. Dr. Riddle asked about the availability of data related to expenditures. Dr. Goldman addressed the difficulties related to comparability of the states when looking at national data. The consultants will try to find a reasonable comparison. He noted that we will do well to find comparisons in Maryland. Dr. Cowdry added that the issue of measurement of system performance must be identified as a principle but will probably not be accomplished within the Task Force time frame. Dr. Rothstein emphasized that it is important to know the baseline in order to be able to measure success.

2. Targeting Services for Specific Populations: Defining Age Groups

There was considerable discussion about the parameters for the definition of transition-aged youth. The group agreed to accept Dr. Goldman's recommendation that we use a definition that will enable us to highlight the effect of Medicaid eligibility changes related to age. The age categories to be used for analysis will be: children 0-12; adolescents 13-17; transition aged youth 18-21; adults 22-64; older adults 65 and over.

3. Targeting Services for Specific Populations: Defining Geographic Regions

Ms. Barclay presented several options for geographic regions. In particular she raised questions about Frederick and Queen Anne's counties. Historically, Frederick County has been included with Western Maryland. More recently it has been added to the Washington Metropolitan area. Similarly Queen Anne's County was always included with the Eastern Shore, but more recently has been added to the Baltimore Metropolitan area. Dr. Cowdry noted that there are also border crossing issues with the District of Columbia. Task Force members were asked to contact the Commission if they have preferences about the definition of geographic regions.

4. Targeting Services for Consideration in Projecting Need

Dr. Cowdry introduced the discussion by observing that adopting Option 1 (inpatient beds only) would result in a superficial and misleading projection of need and would not begin to grapple with the issues. The decision is really between Option 2 (Option 1 plus community-based emergency /crisis stabilization services and diversion services) and Option 3 (Options 1 and 2 plus services used by persons who frequently use or would likely frequently require inpatient psychiatric care). Ms. Maki stated that community hospitals require access to State hospitals as a safety net. Dr. Cowdry responded that the roles of psychiatric hospitals will be the

subject of the next White Paper. Dr. Goldman commented that the availability of data that would assist in looking at diversion services will present a challenge. Dr. Cowdry noted that research about some interventions, such as supported employment, should be included. Ms. Harrison reiterated the importance of considering maintenance services in addition to emergency and crisis services. Dr. Cowdry acknowledged the importance of services that are less directly linked to emergency and crisis service utilization such as housing but noted that the link between these levels of service may be difficult to quantify. Ms. Harrison clarified that she was referring to mental health services such as partial hospitalization and psychiatric rehabilitation. Ms. Barclay suggested that taxonomy of services would be helpful. She requested that Task Force members submit lists of services that they thought should be included. Ms. Katz suggested that there be some information provided about the services as well.

Ms. Harrison requested clarification about the inclusion of both publicly and privately funded inpatient services in the Task Force's mission. She noted the limited levels of care that are available to individuals who have commercial insurance. Ms. Barclay added that we have been discussing accountability *to* payers, but not yet accountability *of* payers. Mr. Cromwell expressed an interest in knowing the insurance status of emergency department users. Difficulties getting authorizations for services were also raised as an influence on emergency department utilization. Ms. Barclay informed the group that the Commission has already collected some information about utilization and reimbursement. She stated that people with mental illnesses who use emergency departments are more likely to be uninsured. Dr. Brandt initiated a discussion of the need to consider subpopulations and the agencies that serve them. These included substance abuse, juvenile justice, human resources, education, disabilities, and nursing homes/long-term care. Mr. Macgill stated that care setting, payer and diagnosis all had to be considered in planning. Ms. Raines cautioned against polarizing community-based and hospital-based services. A continuum of services must be reflected in the plan. Dr. Cowdry supported the importance of focusing on a continuum to fit services to need and use available funding most efficiently. It was clarified that the Task Force had selected Option 3 for targeting services for consideration in projecting need.

5. Planning Strategies/Economic Assumptions

Dr. Riddle said he would opt for a plan based on current resources with some modest growth. Dr. Cowdry clarified that the assumptions about funding growth refer to changes in public sector funding. Dr. Goldman noted that the consultants' understanding is that the mandate also requires the Task Force to look at private payers and private beds in an all-payer system. The Task Force cannot mandate that private payers pay more but the report to the legislature should cover their level of participation. He noted that the #6 ranking of Maryland in per capita spending refers to the public sector. Ms. Raines also supported the option for modest growth. She stated that this approach would assist advocacy groups in benchmarking progress over time. Ms. Harrison noted that there has to be a focus on levels of need and deployment of existing resources with an effort to identify and eliminate duplication. Dr. Cowdry summed up by saying that the Task Force will identify a range of services, ranging from those with a good evidence base to others that appear to be desirable, that are most likely to reduce the need for very expensive hospital resources.

6. Other Issues and Observations

Ms. Maki advocated for including individuals who are well known among providers for being difficult to treat and present disposition problems in emergency departments because no one wants to accept them for service. Mr. Cromwell supported the importance of exploring that issue as it applies to community providers. Ms. Harrison offered two other service barriers for consideration. The first was medication non-compliance related to inability to pay for prescriptions. The other was the unavailability of services during evening, night, and weekend hours. Dr. Riddle added that incentives might be necessary for the development of off-hour services. Further discussion addressed the real problems that individuals have in accessing services. It was mentioned that partial insurance can be as much of a problem as no insurance if the person cannot afford the co-payment. Rural issues of access to services and transportation needs were also raised.

5. Adjournment

The meeting adjourned at approximately 12:15 p.m. Members were asked to review their contact information on the Task Force roster and let Commission staff know if corrections were needed.